LPCC APPLICATION CHECKLIST

CHECKLIST FOR SUBMISSION

- ☐ $150.00 Fee made payable to the Kentucky State Treasurer
- ☐ A separate Verification of Professional Counseling Experience under Supervision, Section 3, from the Application form for each board approved clinical supervisor.
- ☐ Proof of passing national exam scores.
- ☐ Kentucky State Police Background Check
    - Complete the request form at **http://www.kentuckystatepolice.org/background_checks.html**, select the Employment option.
- ☐ FBI Background Check
    - Applicants can get their fingerprints taken at any law enforcement agency and then they will need to be mail to the FBI. The instructions for this can be found at https://www.fbi.gov/services/cjis/identity-history-summary-checks. Please follow the instructions provided to submit your request.
    - Please note that processing time is 14-16 weeks.
    - After submitting the request of the FBI Back Check, qualifying applicants may complete the Affidavit for Licensure form.
    - **FBI Results submitted from FBI Channelers will not be accepted.**
- ☐ If applying for licensure via Endorsement or Reciprocity
    - Please submit verification of current/active license in other state being current and in good standing.
    - Send an official sealed transcript to the Board at PO Box 1360 Frankfort, KY 40601 or overnight to 911 Leawood Dr. Frankfort, KY 40601. These should reflect graduate coursework earned to fulfill the requirements in Section 3.
    - If you have an official sealed transcript in your possession, you may send it with your application. However, it must have remained sealed and be in the original envelope from the school.
- ☐ If applying for licensure via for reciprocity and you have been independently licensed LESS THAN 5 YEARS, you must submit evidence of passing national exam scores and documentation of supervised experience.
- ☐ An applicant seeking approval for licensure with a related degree shall provide syllabi and actual catalog descriptions for all applicable coursework.

KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS
P.O. Box 1360
Frankfort, KY 40602
http://lpc.ky.gov

APPLICATION FOR LICENSED PROFESSIONAL CLINICAL COUNSELOR

Please check one:

	I am currently a LPCA in KY.
	I am independently licensed in another state (for at least 5 years) and am applying for endorsement licensure per KRS 335.527.
	I am currently licensed in a state that has a reciprocal licensure agreement with KY and am applying for reciprocity.
	I have completed the licensing requirements per KRS 335.525(1).

_____

Last Name **First Name** **Middle Name**

(As it should appear on your license certificate and the online license verification system)

_____ _____
Date of Birth **Present Place of Employment**

_____ _____
Mailing Address **Business Address**

_____ _____
Mailing Address **Business Address**

_____ _____
City State Zip Code **City State Zip Code**

_____ _____
Home Telephone Number **Present Place of Employment Telephone Number**

_____ _____
Home E-mail Address **Present Place of Employment E-mail Address**

1. **Are you credentialed as a professional counselor in any other state? ☐ Yes ☐ No**
   If "Yes", Name of Credential: _____ State: _____
   Date of Issue: _____ Expiration Date: _____
   (Attach a letter of good standing from each state.)

2. **Do you or have you ever held any other license, certificate, or registration from a state board in Kentucky or any other state? ☐ Yes ☐ No**
   If "Yes", list license(s), certificate(s) or registration(s) and state(s) and attach a letter of good standing from each state:
   _____

3. **Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended or revoked?**
   ☐ Yes ☐ No
   If "Yes", give details and attach supporting documentation: _____
   _____

4. **Have you ever been convicted of a felony or a misdemeanor (other than minor traffic violations) under the laws of any state in the United States? ☐ Yes ☐ No**

   If "Yes", submit a copy of your final judgment of conviction entered by the court where convicted.

Applicant's Name: _____

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

APPLICANT'S SIGNATURE: _____ _____
(Sign Your Name) **DATE**

_____
(Print Your Name)

SECTION 2 - EXPERIENCE

Begin with your present or most recent counseling position and list, fully and accurately, the details of each job you have held relating to the professional experience you wish to document. You must have completed a minimum of 4,000 hours of experience in the practice of counseling, all of which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include, but not be limited to, a minimum of 1,600 hours of direct counseling with individuals, couples, families, or groups and a minimum of 100 hours of individual, face-to-face clinical supervision with an approved supervisor. The total hour of professional experience includes all hours, both direct and indirect.

Employed From: Mo. ____Yr. ____ *To:* Mo. ____Yr.____ Title of Position: _____ Name of Employer/Agency: _____ Name of Clinical Supervisor: _____ Total Hours of Professional Experience: _____ Total Hours of Direct Counseling: _____	Describe Your Duties: _____ _____ _____ _____ Total Hours of Individual, Face-to-Face Clinical Supervision: _____

Employed From: Mo. ____Yr. ____ *To:* Mo. ____Yr.____ Title of Position: _____ Name of Employer/Agency: _____ Name of Clinical Supervisor: _____ Total Hours of Professional Experience: _____ Total Hours of Direct Counseling: _____	Describe Your Duties: _____ _____ _____ _____ Total Hours of Individual, Face-to-Face Clinical Supervision: _____

Applicant's Name: _____

SECTION 3 - VERIFICATION OF PROFESSIONAL COUNSELING EXPERIENCE UNDER SUPERVISION

(Each clinical supervisor must complete a separate Section 3)

Name of LPCA Supervision Provided to: _____

LPCA License Number: _____

Date Supervision Began: _____ Date Supervision Ended: _____

Date Board Approved Supervision Training Completed: _____

☐ **Copy of Board Approved Supervision Training Attached**

Supervisor

1. _____
   First Middle Last Name
   _____
   Street Address
   _____
   City State Zip Code
   _____
   E-mail Address

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2. Professional Credential of Supervisor: Check the one that applies.

   _____ Licensed Professional Counselor
   _____ Licensed Psychologist
   _____ Licensed Psychiatrist
   _____ Licensed Clinical Social Worker
   _____ Licensed Marriage and Family Therapist
   _____ Nurse with a M.A. Degree and Psychiatric Certification
   _____
   License Number

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3. Graduate Degree(s) Held. (Check all that apply)

	Major Emphasis	Institution	Year Awarded
_____ Masters Degree in	_____	_____	_____
_____ Specialist Degree in	_____	_____	_____
_____ Doctorate	_____	_____	_____

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4. How many hours of professional counseling (direct and indirect) experience has the applicant named above completed while under your supervision? (This is total working time and includes all professional activities.)

   How many hours of direct counseling experience with individuals, groups, families, etc. has the applicant named above completed while under your supervision?

   How many hours of individual, face-to-face, weekly clinical supervision has the applicant named above completed while under your general supervision?

   Do you know of any reason why this person should not be issued a certificate as a professional counselor?
   ☐ **Yes** ☐ **No** If "Yes", please provide details: _____
   _____

Applicant's Name: _____

Please comment on applicant's therapeutic competence and ethical behavior: _____
_____
_____
_____

I, the clinical supervisor named in the above, do hereby certify under penalty of law that the information contained is true, correct and complete to the best of my knowledge and belief.

_____
Name Date

Sections 4 and 5 are not required if you are an LPCA in Kentucky

SECTION 4 - EDUCATION

Please request an official transcript to be mailed from the school to Board office.

School Name	Graduate/Doc. Degree (Qualifying per 201 KAR 36:070)	CACREP Accredited	Regionally Accredited	Graduation Date MONTH	Graduation Date YEAR	NUMBER OF HOURS OR CREDITS	Major/Concentration
		☐	☐				
		☐	☐				
		☐	☐				
		☐	☐				
		☐	☐				
		☐	☐				
		☐	☐				

SECTION 5 - CURRICULUM STANDARDS

PLEASE ENTER *GRADUATE* LEVEL COURSES *ONLY*.
EACH GRADUATE LEVEL COURSE MAY ONLY BE USED IN *ONE AREA*.

1. The helping relationship including counseling theory and practice.				
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Applicant's Name: _____

SECTION 5 – CONTINUED. EACH GRADUATE LEVEL COURSE MAY ONLY BE USED IN *ONE AREA*.

2. Human growth and development.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

3. Lifestyle and career development.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

4. Group dynamics, process, counseling and consulting.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Applicant's Name: _____

SECTION 5 - CONTINUED. EACH GRADUATE LEVEL COURSE MAY ONLY BE USED IN *ONE AREA*.

5. Assessment, appraisal, and testing of individuals.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

6. Social and cultural foundations, including multicultural issues.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Applicant's Name: _____

SECTION 5 - CONTINUED. EACH GRADUATE LEVEL COURSE MAY ONLY BE USED IN *ONE AREA*.

7. Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

8. Research and evaluation.				
Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Applicant's Name: _____

SECTION 5 – CONTINUED. EACH GRADUATE LEVEL COURSE MAY ONLY BE USED IN *ONE AREA*.

9. Professional Orientation: Per 201 KAR 36:070 Section 1(2) requires a three (3) semester hour course, at the minimum, on Professional Orientation and Ethics that is concentrated on the American Counseling Association Code of Ethics. (Studies that provide an understanding of all aspects of professional counseling including counseling history, counseling roles, organizational structures, professional counseling ethics, professional counseling standards, and licensing and credentialing in professional counseling. Example Courses: Introduction to Counseling, Professional Orientation, Legal and Ethical Issues in Counseling.)

Educational institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Practicum/Internship - All applicants shall complete an organized practicum or internship in counseling consisting of at least 600 clock hours.

Educational institution	Prefix & Number	Onsite Supervisor(s)	Semester & Year	Number of Practice Hours

Applicant's Name: _____

Section 6 - CERTIFICATION AND VERIFICATION OF CLINICAL INTERNSHIP/PRACTICUM

INSTRUCTIONS: Complete one form for *each* semester of internship/practicum.

1. **Name of Student/Candidate:** _____

2. **University/College:** _____ **Department** _____

   Degree Program: _____ CACREP ☐ Yes ☐ No

   University/College Internship Supervisor: _____

   Degree and Discipline of University/College Internship Supervisor: _____

   License/Credential Held by University/College Supervisor: _____ License #: _____

   Year Internship/Practicum Completed: _____ Semester: _____ Quarter: _____

3. **Agency(s) Internship Completed:** _____

   Name of Onsite Clinical Supervisor(s) Please Print: _____

   Degree and Discipline of Onsite Clinical Supervisor: _____

   License/Credential Held by Onsite Clinical Supervisor: _____ License #: _____

   Briefly describe nature of practice/experience including populations student worked with:

   _____

   _____

   _____

   _____

   _____

   Hours Experienced in Internship/Practicum: Direct Hours _____ Indirect Hours _____

   Individual Supervision _____ Group Supervision _____ Total Hours _____

4. **University/College Supervision Hours:**

   Individual Supervision _____ Group Supervision _____

_____ _____

Student/Candidate Signature **Date**

_____ _____

University Supervisor/Instructor Signature **Date**